MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

69995

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years 2 months 28 days

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland / County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)

Street No. -
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: ALLERDICE, Alexander

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): September 23, 1883

8. AGE: Years	Months	Days	If less than one day
62		29	- hrs. - min.

9. Birthplace: Lonaconing, Md.
(Town, county, and state)

10. Usual occupation: -

11. Industry or business: -

FATHER
12. Name: Alexander Allerdice
13. Birthplace: Scotland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Scotland

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 10-24-45 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.

18. Funeral director: Pennington & Son
Address: Pennington & Son, Havre de Grace, Md.

19. Oct. 29 1945 (Date rec'd by registrar) Irma E. Dugle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 1945 at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1933 to October 22 1945 and that I last saw him alive on October 22 1945

Immediate cause of death	DURATION
Myocardial Degeneration	Over 1 year
Due to: Coronary Arteriosclerosis	Over 1 year
Due to:	
Other conditions: Dementia Precox, Paranoid Type	Over 12 years

(Include pregnancy within 3 months of death)

Major findings of operation: -

Date of op.: -

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: A. E. Pennington
A. E. TROLLINGER, Lt. Col., M.C., Clinical Director, Veterans Administration
Address: Perry Point, Md. M.D. or other
Date signed: 10-23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

09996

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 90

1 PLACE OF DEATH
County Cecil

Village or City Warwick (No. ____ St.: ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Baynard Alexander Anderson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	Black	widowed

6 DATE OF BIRTH: Dec. (Month) 23 (Day), 1871 (Year)

7 AGE: 73 yrs. 9 mos. 10 ds. (If LESS than 1 day ____ hrs. or ____ min.)

8 OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or establishment in which employed or (employer): —

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: George Mercer

11 BIRTHPLACE OF FATHER (State or country): md —

12 MAIDEN NAME OF MOTHER: — Anderson

13 BIRTHPLACE OF MOTHER (State or country): ? — md. ?

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Francis Anderson

(Address) Warwick — Md.

15 Filed Oct 24 1945 Chas. J. Burbe Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: October 3 (Month) (Day), 1945 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 12 1945 to Oct 3 1945, that I last saw h[illegible] alive on Oct 3 1945, and that death occurred on the date stated above, at 11:35 A.m.

The CAUSE OF DEATH * was as follows:

Cerebral Arterio-Sclerosis

(Duration) ____ yrs. 5 mos. ____ ds.

Contributory Secondary: General Arterio-Sclerosis

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Dorsey W. Sears M. D.

Oct 3 1945 (Address) Middletown. Del.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bohemia md.	Oct 8, 1945
20 UNDERTAKER	ADDRESS
Austin O. Caulk	109 Lake St Middletown Del

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

V. S. No. 1.

N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Corcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examplo: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-G)

CERTIFICATE OF DEATH

09997

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil Co.
City or town: Pearryville, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World war II.

3.(a) FULL NAME: Noah Calvin Barnes.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Clara M. Barnes.
6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): July 9, 1911

8. AGE: Years: 34 | Months: 2 | Days: 29 | If less than one day: hrs. min.

9. Birthplace: Trenton (Town, county, and state) New Jersey
10. Usual occupation: Machinist Helper.
11. Industry or business: Boat Yard

FATHER
12. Name: Charles F. Barnes.
13. Birthplace: Westminster, Md.

MOTHER
14. Maiden name: Isabelle Broughton
15. Birthplace: Cecil Co. Md.

16. Informant: Isabelle Barnes
Address: Perryville, Md.

17. Burial (Burial, cremation, or removal: Which?) Date thereof: Oct. 10, 1945 (month) (day) (year)
Cemetery or crematory: St Marks
Location: Perryville, Md (Rural)

18. Funeral director: Lena Patteson & Son
Address: Perryville, Md.

19. Oct. 10 1945 (Date rec'd by registrar) Irene E. Dunbar (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1945 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Embolism	
Due to	
Due to War. Traumatic injury	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. C. Dodson M.D. Medical Examiner for Cecil County
Address: Elkton Md. M. D. or other
Date signed: 10-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-E)

CERTIFICATE OF DEATH

69998 Reg. Dist. No. 96

1. PLACE OF DEATH:

County CECIL

City or town Veterans Administration, Perry Point, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs. 8 mo. 8 da.

Hospital, institution, or street address where death occurred: VETERANS ADMINISTRATION, PERRY POINT, MD.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ~~Montgomery~~ Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. -

(If rural, give LOCATION)

2.(a) If veteran, name war WW I

3.(a) FULL NAME BENSON, Orion R.

3.(b) Social Security Number -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Unknown maiden name Mrs. Mayme Benson

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.) 9-25-1883

8. AGE: Years 62 | Months | Days 22 | If less than one day: - hrs. - min.

9. Birthplace Goshen, Md. (Town, county, and state)

10. Usual occupation Auto Mechanic

11. Industry or business -

FATHER 12. Name John E. Benson

13. Birthplace Montgomery County, Md.

MOTHER 14. Maiden name Rebecca A. Dowden

15. Birthplace Montgomery County, Md.

16. Informant Hospital Records

Address Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 10-18-1945 (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Va.

18. Funeral director Cunningham & Son

Address Havre de Grace, Md.

19. Oct. 18 1945 (Date rec'd by registrar) Irene E. Lang Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1945 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-9- 1936 to 10-17 1945

and that I last saw him alive on 10-17- 1945

	DURATION
Immediate cause of death: Cerebral Thrombosis	1 week
Due to: Syphilis of Central Nervous System, Meningo Encephalitic type	Over 9 yrs.
Due to:	
Other conditions: Psychosis with Syphilis of Central Nervous System, Meningo-Encephalitic Type (Include pregnancy within 3 months of death)	Over 9 yrs.

Major findings of operations: - Date of op. -

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE A.E. Trollinger

A.E. TROLLINGER, Lt. Col., M.C. CLINICAL DIRECTOR, M.D. or other

Address VETERANS ADMINISTRATION, PERRY POINT, MD. Date signed 10-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

09999

Reg. Dist. No. 92

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 51 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? Union Hospital 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Morris K. Biddle

3.(b) Social Security Number: 212-22-2851

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Minnie E. Biddle
6.(c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): May 23 1894

8. AGE: Years: 51 Months: 4 Days: 11 If less than one day: hrs. min.

9. Birthplace: Elkton Cecil Maryland
(Town, county, and state)
10. Usual occupation: Clerk (Hotel)
11. Industry or business:

FATHER
12. Name: Henry Biddle
13. Birthplace: Elkton Md

MOTHER
14. Maiden name: Mary F. Clark
15. Birthplace: Delaware

16. Informant: Henry Biddle
Address: Elkton Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 8 1945 (month) (day) (year)
Cemetery or crematory: Elkton Cemetery
Location: Elkton Md
18. Funeral director: H. W. Pippin
Address: Elkton Maryland

19. Oct 8 1945 (Date rec'd by registrar) J. R. Fraser (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4 1945, at 5 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 1945, to Oct 4 1945, and that I last saw h... alive on Oct. 4 1945

Immediate cause of death	DURATION
Acute Coronary Occlusion	
Due to: Coronary Sclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Donald V. Spreadley M.D.
M. D. or other
Address: Elkton, Md. Date signed: Oct. 5

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(170-E)

10(C-1)

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Union Hosp. Elkton Md
How long in hospital or institution? 3-4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County: Phila.
City or town: Philadelphia
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4369 Pechin St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Eileen Mary Broos.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Single.

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 18. 1930.

8. AGE: Years 15 | Months 3 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)

10. Usual occupation School Girl.

11. Industry or business

FATHER
12. Name Alfred F. Broos.
13. Birthplace Philadelphia Pa.

MOTHER
14. Maiden name Anna G. O'Donnell.
15. Birthplace Roxborough. Pa.

16. Informant Mrs. Anna L. Littlewood.
Address Chesapeake City Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 8 45 (month) (day) (year)
Cemetery or crematory Roxborough, Pa
Location Phila. Pa.

18. Funeral director H. W. Pippin
Address Elkton Md

19. Oct 8 19 45 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 19 45 at 11.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured frontal bone & Contused brain.	
Due to Fracture of base of skull.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 10-6-45
Where did injury occur? Chesapeake City Cecil Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway 213
Means of injury Automobile Injured at work?

23. SIGNATURE R. L. Dodson M.D. Medical Examiner for Cecil County
M. D. or other
Address Rising Sun Md Date signed 10-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-A)

10001

FILE No. G 99 NOV 1 1945

CERTIFICATE OF DEATH

★ Reg. Diat. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Principio Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Principio
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Lydia Buchanan

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William D Buchanan
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 8 1868

8. AGE: Years	Months	Days	If less than one day
76	7	11	hrs. min.

9. Birthplace: Principio, Cecil, Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: Samuel ~~George~~ J. Winchester
13. Birthplace: Md

MOTHER
14. Maiden name: Mary E Murphy
15. Birthplace: Md

16. Informant: Mrs Helen Ennis
Address: Perryville R D 1 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 23 1945 (month) (day) (year)
Cemetery or crematory: Principio Methodist
Location: Principio Maryland
18. Funeral director: Joseph R. Linton
Address: North East Md

19. Oct. 22 1945 (Date rec'd by registrar) Irene E. Dunlady Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 19th 1945 at 10.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25 1945 to Oct 18th 1945 and that I last saw h[illegible] alive on Oct 18th 1945

	DURATION
Immediate cause of death: Chronic Myocarditis	about a year
Due to: Arterio-Sclerosis and Hypertension	" " "
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: T A McKnight M.D.
M. D. or other
Address: Elkton Md Date signed: Dec. 20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-2)

CERTIFICATE OF DEATH

10002

★ Reg. Dist. No. 96

1. PLACE OF DEATH:

County CECIL

City or town BAINBRIDGE, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 DAYS

Hospital, Institution, or street address where death occurred: U.S. NAVAL HOSPITAL, NAVTRACEN, BAINBRIDGE, MARYLAND.

How long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 North Hilton
(If rural, give LOCATION)

2.(a) If veteran, name war WORLD WAR II ✓

3.(a) FULL NAME Thomas Edward C O N N O R S

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Wife: Saraphine Connors

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 8, 1906

8. AGE: Years	Months	Days	If less than one day
39	2	2	..... hrs. ..... min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation U.S. Navy

11. Industry or business

FATHER — 12. Name Unknown

FATHER — 13. Birthplace Unknown

MOTHER — 14. Maiden name Unknown

MOTHER — 15. Birthplace Unknown

16. Informant U.S. Naval Hospital, NavTraCen.

Address Bainbridge, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 11, '45 (month) (day) (year)

Cemetery or crematory Chambers Funeral Home

Location Washington, D. C.

18. Funeral director Lee A. Patterson & Son

Address Perryville, Md.

19. Oct. 11, 19 45 (Date rec'd by registrar) Irma E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 October 19 45 at 1212 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 October 19 45, to 10 October 19 45 and that I last saw him alive on 10 October 19 45

Immediate cause of death	DURATION
ULCER, DUODENUM (BLEEDING)	5 DAYS
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Ulcer, Duodenum

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE James B. Black Jr. M. D. or other

Address USNH, Bainbridge, Md. Date signed 10-10-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-A)

CERTIFICATE OF DEATH

10003

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 8 mo. 3 days

Hospital, Institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: ~~6~~

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2918 O'Donnell Street

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I ✓

3.(a) FULL NAME: COX, Robert J.

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): June 29, 1890

8. AGE: Years	Months	Days	If less than one day
55	3	28	– hrs. – min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Iron Worker

11. Industry or business: –

FATHER — 12. Name: Unknown

13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. (Burial, cremation, or removal. Which?) Removal — Date thereof: Oct. 31, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Pennington & Son

Address: PENNINGTON & SON, Havre de Grace, Md.

19. (Date rec'd by registrar) Oct 31 1945 — Registrar: Irene E. Dunfee

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27, 1945, at 11:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 24, 1941, to October 27, 1945 and that I last saw h... im ...alive on October 27, 1945

Immediate cause of death	DURATION
Malignancy, pulmonary, left upper lobe	over 7 months
Due to	
Due to	
Other conditions: Epilepsy Post Traumatic with mental deterioration	Over 4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: –

Date of op.: –

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: – Date of: –

Where did injury occur? – (City or town) – (County) – (State)

Injured at home, farm, industry, public place (where?): –

Means of injury: – Injured at work? –

23. SIGNATURE: A.E. Trollinger, Lt. Col., M.C. Clinical Director

Address: Veterans Administration, Perry Point, Md. Date signed: 10-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

10004

CERTIFICATE OF DEATH

Reg. Dist. No. 9D

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit Town

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): All Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Herman Dorsey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

8 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 19 1882

8. AGE: Years: 63 Months: Days: If less than one day: hrs. min.

9. Birthplace: md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: James Dorsey

13. Birthplace: md

MOTHER — 14. Maiden name: Mary E. Rose

15. Birthplace: md

16. Informant: Ida B. Rose

Address: md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 31-45 (month) (day) (year)

Cemetery or crematory: Oliver Hill md

Location: Oliver Hill md

18. Funeral director: Austin C. Caulk

Address: 109 Lake St, Middletown Del.

19. Oct. 31, 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 26 1945, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1st 1945 to Oct 26th 1945, and that I last saw him alive on Oct 26th 1945.

Immediate cause of death	DURATION
Mitral Stenosis & Asthma	1 yrs
Due to Hypertension	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: G. E. Osland M. D. or other

Address: Millington Md Date signed: Oct 26 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

10005

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Union Hosp.

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: North East Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John C. Duncan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Annie J. Duncan

6.(c) If alive, give age: 8[illegible] years

7. Birth date of deceased (mo., day, yr.): Feb 14 1865

8. AGE: Years	Months	Days	If less than one day
80			...hrs. ...min.

9. Birthplace: Penna. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: James C. Duncan

FATHER — 13. Birthplace: Penna.

MOTHER — 14. Maiden name: Christina Krouse

MOTHER — 15. Birthplace: Penna.

16. Informant: John Duncan Jr.

Address: Elkton Md

17. Burial, cremation, or removal. Which?: Burial — Date thereof: Oct 8 1945 (month) (day) (year)

Cemetery or crematory: Airville

Location: York Co. Pa.

18. Funeral director: J. E. Fraser

Address: Rising Sun Md

19. Oct 6 1945 (Date rec'd by registrar) — J R Fraser, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 5 1945; at 2 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 1945 to Oct 5 1945 and that I last saw h. alive on Oct. 4 1945

Immediate cause of death	DURATION
Gangrene of foot, right	Sept. 1, 1945
Due to: arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Richard V. Speaker, M. D. or other

Address: Elkton, Md. Date signed: Oct 5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

10006

Reg. Diat. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Chiles
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, Institution, or street address where death occurrod:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Chiles
(If outside city or town limits, writs RURAL and give nearest town)
Street No.
(If rural, gives LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Patrick J. Dunn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 17, 1870

8. AGE: Years 75 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Massey Md.
(Town, county, and state)

10. Usual occupation: retired farmer

11. Industry or business

FATHER
12. Name: Thomas Dunn
13. Birthplace: Ireland

MOTHER
14. Maiden name: Bridgett Nolan
15. Birthplace: Ireland

16. Informant: Mrs Mary Dunn
Address: Chilles Md

17. buried Date thereof Oct 24 '45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or cromatory: Elkton Catholic
Location

18. Funeral director: R. J. Jones
Address: Newark. Del.

19. Oct 22 1945 F H Frazer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21, 1945 at 1:15 PM

21. I CERTIFY that death occurrod on the date above statod; that I attended deceased from September 5, 1945 to Oct. 21, 1945
and that I last saw him alive on Oct. 19, 1945

Immediate cause of death	DURATION
Cardiovascular Renal Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the canse to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicido, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (whore?)
Means of injury Injured at work?

23. SIGNATURE: D. Chad V. Grealey M. D. or other
Address: Elkton, Maryland Date signed 10/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40-7)

10007

CERTIFICATE OF DEATH

★ Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Port Deposit (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Founds

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 3, 1870

8. AGE:

Years	Months	Days	If less than one day
75	2	23	..... hrs. ..... min.

9. Birthplace: Cecil co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Pearce Founds

FATHER — 13. Birthplace: Cecil co. Md.

MOTHER — 14. Maiden name: Annie Campbell

MOTHER — 15. Birthplace: Cecil co. Md.

16. Informant: Mollie Founds

Address: East Detroit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 28 1945 (month) (day) (year)

Cemetery or crematory: Fatherwell

Location: Port Deposit, Md. Rural

18. Funeral director: C. A. Patterson & Son

Address: Perryville, Md.

19. Oct 26 1945 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 26, 1945 at 7:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19, 1945 to Oct. 26, 1945 and that I last saw him alive on Oct. 25, 1945

Immediate cause of death: Carcinoma of Liver — DURATION

Due to:

Due to:

Other conditions: Coronary Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas V. Greene M.D. M. D. or other

Address: Elkton, Md. Date signed Oct. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 57-E

CERTIFICATE OF DEATH

10008

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: CECIL
City or town: Veterans Administration, Perry Point, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 yrs. 1 mo. 4 da.
Hospital, institution, or street address where death occurred: Veterans Administration, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. Va. County: McDowell
City or town: Kyle
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American ✓

3. (a) FULL NAME: FULKS, Walter Lee

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 14, 1878

8. AGE: Years	Months	Days	If less than one day
67	6	13	— hrs. — min.

9. Birthplace: Kyle, W. Va. (Town, county, and state)
10. Usual occupation: Meat Cutter
11. Industry or business: —

FATHER
12. Name: James W. Fulks
13. Birthplace: Lynchburg, Va.

MOTHER
14. Maiden name: Katie Lee
15. Birthplace: Lynchburg, Va.

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: October 29, 1945 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. Oct. 29 19 45 (Date rec'd by registrar) Irma E. Dunlap Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 19 45, at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 23 19 34, to October 27 19 45 and that I last saw h. im alive on October 27 19 45

Immediate cause of death	DURATION
Cancer of Prostate	2 yrs.
//// Arteriosclerosis, general	Undetermined
Due to	
Due to	
Other conditions: Arteriosclerosis, general and cerebral (Include pregnancy within 3 months of death)	Undetermined.

Major findings of operations: —
Date of op.: —
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: C. E. Trollinger
C. E. TROLLINGER, Lt. Col., M.C., Clinical Director
Address: Veterans Administration, Perry Point, Md. Date signed: 10-29-45


RECEIVED
OCT 31 1945
RUREAU V.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (119-a)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 10009 42

1. PLACE OF DEATH:

County Cecil

City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? Union Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Cecil

City or town Georgetown Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Lee Grassaway

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Single

6.(b) Name of husband or wife Baby

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 24, 1945

8. AGE:

Years	Months	Days	If less than one day
	3	25	..... hrs. ..... min.

9. Birthplace Union Hospital Elkton
(Town, county, and state)

10. Usual occupation Baby

11. Industry or business

FATHER
12. Name Robert L. Grassaway
13. Birthplace Maryland

MOTHER
14. Maiden name Lillian Brown
15. Birthplace Maryland

16. Informant Robert L. Grassaway

Address Georgetown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 22 1945 (month) (day) (year)

Cemetery or crematory Wesley Memory

Location Elkton Md

18. Funeral director Edward Sellers

Address Millington Md.

19. Oct 22 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19 1945 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-18 1945 to 10-19 1945

and that I last saw him alive on 10-19 1945

	DURATION
Immediate cause of death Malnutrition & Sclerema Neonatorum	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R L Dodson M.D.
M. D. or other

Address Rising Sun Md. Date signed 10-20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 16010 96

1. PLACE OF DEATH:

County: Cecil

City or town: U.S.N.T.C. Bainbridge, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, institution, or street address where death occurred:
U.S.N.T.C. Bainbridge, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Florida County: Hillsborough

City or town: Tampa
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3506 Central Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War #2

3.(a) FULL NAME: GRAY, Mitchell Evert Jr.

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12-18-26

8. AGE: Years	Months	Days	If less than one day
18	9	15	...m. ...hrs. ...m. ...min.

9. Birthplace: Florida (Town, county, and state)

10. Usual occupation: Stewards Mate

11. Industry or business: U. S. Navy

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Service Record

Address: U.S.N.T.C. Bainbridge, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 5, 1945 (month) (day) (year)

~~Cemetery or crematory~~ Pughsley's Funeral Home

Location To Tampa Florida

18. Funeral director: Leda Patterson & Son

Address Perryville, Md.

19 Oct 5 1945 (Date rec'd by registrar) Irma E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 October 1945 at 1145 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~XXX~~ at 1145 AM 3 October 1945, to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Dilatation Cardiac, Acute	
Due to: Early Syphilis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations:

Date of op.

Autopsy results: Dilatation Right Auricle and Ventricle

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. T. HUNTER (MC) USNR
M. D. or other

Address: USNTC, Bainbridge, Md. Date signed 10-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

10011 92

Reg. Dist. No.

1. PLACE OF DEATH:
County: Cecil County
City or town: Elkton Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil County
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 113 Booth
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Alfred Harris

3.(b) Social Security Number: 214-16-5293

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Irene Harris
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): February 17, 1878

8. AGE: Years	Months	Days	If less than one day
67			hrs. min.

9. Birthplace: Elkton Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: William Harris
13. Birthplace: Maryland

MOTHER
14. Maiden name: Harriet Unknown
15. Birthplace: Maryland

16. Informant: Irene Harris
Address: 113 Booth Street, Elkton Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 29, 1945 (month) (day) (year)
Cemetery or crematory: Providence Cemetary
Location: Elkton Maryland
18. Funeral director: Edwin K. Bell
Address: 909 Poplar St. Wil. Del.
19. Oct 29 1945 (Date rec'd by registrar) F. R. Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 25 1945 at 1:15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 30 1945 to Oct 25 1945 and that I last saw him alive on Oct. 23 1945

Immediate cause of death	DURATION
Carcinoma of Stomach	1 mo.
Due to	
Due to	
Other conditions: Coronary Thrombosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James L. Johnson M.D
M. D. or other
Address: Elkton, Md. Date signed: 10/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

10012

CERTIFICATE OF DEATH

★ Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton - Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Childs —
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Almshouse
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Hugh Harry

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	divorced

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1868

8. AGE: 77 Years	Months	Days	If less than one day
	unknown		..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Jolin Harry
13. Birthplace: unknown

MOTHER
14. Maiden name: Rose Webber
15. Birthplace: unknown

16. Informant: The deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-15-45 (month) (day) (year)
Cemetery or crematory: Hopewell Cemetery
Location: Cecil Co Md.
18. Funeral director: J E Tyson
Address: Rising Sun Md.
19. Oct 13 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 12 1945 at 10:a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 7th 1945 to Oct 12 1945
and that I last saw him alive on Oct 12-45 1945

Immediate cause of death	DURATION
Chronic Myocarditis	unknown
with severe coronary sclerosis	
Due to 10 days	
Due to	
Other conditions General Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: V. H. McKnight M.D. (M. D. or other)
Address: Elkton Md Date signed 10/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

Evidence for the charge of age is shown on

STATE OF MARYLAND—CERTIFICATE OF DEATH

FILE No. G98 OCT 19 1945 (1066) 10013

1. PLACE OF DEATH

County Cecil — Registration Dist. No. 90

Village or City Warwick — No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 18 yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME John Holmes — If U. S. Veteran, specify WAR ____

(a) Residence: No. Warwick — Md. — St., ____ Ward. ____

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Black	Married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Ellen Henry

6. DATE OF BIRTH (month, day, and year) 2/28 — 1868 — 1867.

7. AGE	Years	Months	Days	It LESS than 1 day, ____ hrs. or ____ min.
	77	7	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation ____

12. BIRTHPLACE (city or town) ____ (State or country) Virginia

FATHER

13. NAME Don't Know

14. BIRTHPLACE (city or town) — (State or country)

MOTHER

15. MAIDEN NAME Don't Know

16. BIRTHPLACE (city or town) — (State or country)

17. INFORMANT Ellen Henry Holmes

(Address) Warwick, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Centon md Date Oct 10, 1945

19. UNDERTAKER Austin P. Caulk

(Address) 109 Lake St. Middletown Del

20. FILED Oct 8th, 1945 Jarrod Burke

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Oct (Month) 5 (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1945, to Oct 5, 1945

I last saw h. alive on Oct 5, 1945; death is said to have occurred on the date stated above, at 10 — A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Bronchial Asthma — Bronchiectasis	? —
Other Contributory Causes of Importance:	
Arteriosclerosis —	? —

Name of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy? ____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of Injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury ____

Nature of Injury ____

24. Was disease or injury in any way related to occupation of deceased? ____

If so, specify ____

(Signed) Dorsey W. Sems M. D.

(Address) ____

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (98d)

CERTIFICATE OF DEATH

10014

★ Reg. Diat. No. 94

1. PLACE OF DEATH:
County: Cecil
City or town: North East
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: North East
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Harry Coleman Jones

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Susie James
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 5 1875

8. AGE:

Years	Months	Days	If less than one day
70	5	16	..... hrs. ..... min.

9. Birthplace: Harford Co., Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Robert Jones
13. Birthplace: Harford Co. Md
MOTHER 14. Maiden name: Martha Ward
15. Birthplace: Harford Co. Md.
16. Informant: Susie Jones
Address: North East, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 24 1945 (month) (day) (year)
Cemetery or crematory: Charlestown, Md.
Location: Charlestown, Md.
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. 10-23 1945 Lydia E. Evans
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 21 1945 at 2. A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1945 to Oct 21 1945 and that I last saw him alive on Oct 22 1945

Immediate cause of death	DURATION
myocarditis	4 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. Blevins M. D. or other
Address: North East Md Date signed: 10-23-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

10015

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Providence

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Rural Elkton, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Providence

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Flora Kelly

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: William Kelly

6.(c) If alive, give age: [redacted] years

7. Birth date of deceased (mo., day, yr.): Nov. 21, 1859

8. AGE: Years: 85 | Months: 11 | Days: 1 | If less than one day: ... hrs. ... min.

9. Birthplace: Regie Scotland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Alexander Fraser

13. Birthplace: Scotland

MOTHER — 14. Maiden name: Henrietta Shaw

15. Birthplace: Scotland

16. Informant: William Kelly (son)

Address: Elkton, R.F.D. 5, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 25, 1945 (month) (day) (year)

Cemetery or crematory: Brookview

Location: Rising Sun, Md.

18. Funeral director: Florence E. Donnelly

Address: Elkton R.F.D. 5 Md

19. Oct 23 1945 (Date rec'd by registrar) F. P. Jaggers Registrar

MEDICAL CERTIFICATION 45 48

20. DATE OF DEATH: October 22 1945 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1945 to Oct. 22 1945

and that I last saw h... alive on Oct. 21 1945

Immediate cause of death	DURATION
Uremia —	Sept —
Due to: Cardio-vascular-renal disease —	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Edward F. Dreaney, M.D. (M. D. or other)

Address: Elkton, Md. Date signed: Oct 23

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(109) ★ 100194

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: North East.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: North East.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Irving John Kendall Jr.

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): Mar. 26 1944

8. AGE:

Years	Months	Days	If less than one day
1	7	12	hrs. min.

9. Birthplace: Elkton Md. (Town, county, and state)

10. Usual occupation: child

11. Industry or business:

FATHER — 12. Name: Irving J. Kendall Sr.

FATHER — 13. Birthplace: Guilford Md.

MOTHER — 14. Maiden name: Edith Mary LeCompte

MOTHER — 15. Birthplace: Rochester N.Y.

16. Informant: Irving J. Kendall Sr.

Address: North East Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 11 1945 (month) (day) (year)

Cemetery or crematory: Catholic

Location: Elkton, Md

18. Funeral director: Joseph R Grant

Address: North East. Md

19. 10/10 1945 (Date rec'd by registrar) Lida B. Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 6 1945, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute	
Due to: Pneumonia	
Due to: (Fract. History)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. L. Woodcock M.D. Medical Examiner Cecil County

M. D. or other

Address: North East Md Date signed: 10-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10017

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elk Mills Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elk Mills Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Edgar Lawson

3.(b) Social Security Number 216-03-8763

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Mrs Susie Lawson

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Dec 18 - 1888

8. AGE: Years: 57 | Months: 9 | Days: 14 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Tenn. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER

12. Name: Thomas Lawson

13. Birthplace: Tenn.

MOTHER

14. Maiden name: Ella Medlock

15. Birthplace: Tenn.

16. Informant: Mrs Susie Lawson

Address: Elk Mills Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 4. 1945 (month) (day) (year)

Cemetery or crematory: Cherry Hill Med.

Location: Maryland

18. Funeral director: P. I. James

Address: Newark Del

19. Oct 2 1945 I R Frazer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1 1945, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1, 1945 to Oct 1 1945 and that I last saw him alive on Sept 29 1945

Immediate cause of death	DURATION
Myocarditis	2 mo
Due to	
Due to	
Other conditions Bilateral Tuberculosis	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: James L. Johnson M.D. (M. D. or other)

Address: 225 Lea Blvd Wilm Del Date signed: 10-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

10018

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: VETERANS ADMINISTRATION, PERRY POINT, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yr. 11 mo. 7 da.

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Fla. County: Duval

City or town: Jacksonville, Fla.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt. 1 Box 179-B
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American War

3.(a) FULL NAME: LONG, Joseph

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): 1-15-1870

8. AGE: Years	Months	Days	If less than one day
75	9	0	- hrs. - min.

9. Birthplace: Richmond, Va.
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: -

FATHER
12. Name: Joseph Long
13. Birthplace: Fredericksburg, Va.

MOTHER
14. Maiden name: Mary McKenna
15. Birthplace: Ulster, Ireland

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal, Which?) Date thereof: 10-19-1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

16. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19 Oct 19 19 45 (Date rec'd by registrar) Irma E. Dunphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15 19 45 at 1:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 8 19 35 to October 15 19 45 and that I last saw him alive on October 15 19 45

Immediate cause of death	DURATION
Myocardial Degeneration	Over 1 yr.
Due to: Coronary Arteriosclerosis	Over 1 yr.
Due to:	
Other conditions: Psychosis with Cerebral Arteriosclerosis	About 10 years

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op.: -

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of: -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: A. E. Trollinger, Lt. Col., M.C. Clinical Director or other

Address: Veterans Administration, PERRY POINT, MD. Date signed: 10-17-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

10019

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Union Hosp.
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Cecil
City or town: Fair Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME M
Harry Mackie

3.(b) Social Security Number 222-10-3191

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Dora Lott Mackie
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept 27 1870

8. AGE: Years 75 Months — Days 25 If less than one day ____ hrs. ____ min.

9. Birthplace: Fair Hill Cecil Co Md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: John A. Mackie
13. Birthplace: Ind

MOTHER
14. Maiden name: Mary Ellen McVey
15. Birthplace: Penna

16. Informant: Paul Mackie
Address: Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 25-45 (month) (day) (year)
Cemetery or crematory: Sharps
Location: Fair Hill, Md
19. Funeral director: Joseph R. Grant
Address: North East Md

19. Oct 24 1945 (Date rec'd by registrar) J R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22, 1945, at 10:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 17, 1945, to Oct. 22, 1945 and that I last saw him alive on Oct. 22, 1945

Immediate cause of death	DURATION
Bronchial Pneumonia; Advanced Rheumatic Heart Disease	10/10
Due to	
Due to	
Other conditions: Cerebral Thrombosis	10/20

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: Milford W. Sprecher M. D. or other
Address: Elkton, Md. Date signed: 10/23/45

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170c)

CERTIFICATE OF DEATH

10020

Reg. Dist. No. 92

1. PLACE OF DEATH: County Cecil City or town Elkton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Cecil
City or town Elkton (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Walter C. Marcus
3.(b) Social Security Number 214-03-0855

4. Sex M. 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Agnes Marcus
6.(c) If alive, give age 61 years
7. Birth date of deceased (mo., day, yr.) Sep 10 1884
8. AGE: Years 61 Months Days 22 If less than one day ...hrs. ...min.
9. Birthplace Elkton, Md (Town, county, and state)
10. Usual occupation Maryland Display Co
11. Industry or business
FATHER 12. Name Hylan Marcus
13. Birthplace Elkton, Md
MOTHER 14. Maiden name Anna Price
15. Birthplace Elkton, Md
16. Informant Marian Marcus
Address Elkton, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 5/45 (month) (day) (year)
Cemetery or crematory Elkton Cemetery
Location Elkton, Md
18. Funeral director H. W. Pippin
Address Elkton, Md
19. Oct 4 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1945, at 12:10 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....
and that I last saw h... alive on ....19....
Immediate cause of death Compound
Due to fracture of skull & rt. leg
Due to fracture of lower left leg.
DURATION
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 10-2-45
Where did injury occur? Elkton Cecil Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Route 40
Means of injury Automobile Injured at work?
23. SIGNATURE R. L. Dodson M.D. Medical Examiner Cecil County M. D. or other
Address Rising Sun Md Date signed 10-2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10021

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: VETERANS ADMINISTRATION PERRY POINT, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs 11 mo. 10 da.

Hospital, institution, or street address where death occurred:
VETERANS ADMINISTRATION, PERRY POINT, MD.

How long in hospital or institution? SAME AS ABOVE

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Tennessee County: Roane

City or town: Oliver Springs
(If outside city or town limits, write RURAL and give nearest town)

Street No. -
(If rural, give LOCATION)

2.(a) If veteran, name war: W.W.I

3.(a) FULL NAME: MC GLOTHIN, James C.

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): January 28, 1896

8. AGE:

Years	Months	Days	If less than one day
49	8	17	...m. ...hrs. ...m. ...min.

9. Birthplace: Coalfield, Tennessee
(Town, county, and state)

10. Usual occupation: Farmer & Miner

11. Industry or business: -

FATHER
12. Name: James C. McGlothin, Sr.
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary Jackson
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: October 15, 1945 (month) (day) (year)

Cemetery or crematory: Oliver Springs Cemetery

Location: Oliver Springs, Tennessee

18. Funeral director: Pennington & Son
Address: Pennington & Son, Havre de Grace, Md.

19. Oct 15 19 45 Irene E. Danforth
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15 1945 at 10:55A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 5 1936, to October 15 1945

and that I last saw him alive on October 15 1945

Immediate cause of death: TUBERCULOSIS, Pulmonary, Chronic, far advanced — DURATION: Over 10 years

Due to:

Due to:

Other conditions: Dementia Precox, Hebephrenic Type — DURATION: Over 14 years

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op. -

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE: A.E. Trollinger, Lt. M.C., Clinical Director

Address: Veterans Administration Perry Point, Md. Date signed: 10-15-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10022

CERTIFICATE OF DEATH

Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: North East
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: North East
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William L. McKinney

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary McKinney
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 5 1866

8. AGE:

Years	Months	Days	If less than one day
79	2	12	hrs. min.

9. Birthplace: North East, Cecil Co. Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Thos B. McKinney
13. Birthplace: Md

MOTHER
14. Maiden name: Elizabeth Mahoney
15. Birthplace: Md

18. Informant: Arthur McKinney
Address: North East Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 20-45 (month) (day) (year)
Cemetery or crematory: Methodist
Location: North East Md
18. Funeral director: Joseph R Evans
Address: North East Md

19. 10/20 1945 Lida V. Evans
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 17 1945 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1945 to Oct 17 1945 and that I last saw h[illegible] alive on Oct 12 1945

Immediate cause of death: myocarditis — DURATION: 1 yr

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. B. Cecil M.D. or other
Address: North East Md Date signed: 10-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1860

10023

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Union Hosp. Elkton Md
How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Colora
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Letitia Muldoon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Widowed

6.(b) Name of husband or wife: Robert H. Muldoon

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 4 1860

8. AGE: Years: 85 | Months: 4 | Days: 11 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Rock Springs Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Andrew J. Barrett
13. Birthplace: Maryland

MOTHER
14. Maiden name: Amanda Culbertson
15. Birthplace: Peyona

16. Informant: Robert Muldoon
Address: Colora Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 19-45 (month) (day) (year)
Cemetery or crematory: Brookmere
Location: Rising Sun Md.

18. Funeral director: J E Pugsley
Address: Rising Sun Md.

19. Oct 17 1945 F R Frazer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 15 1945 at 9:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20 1945 to Oct 15 1945 and that I last saw her alive on Oct 14 1945

Immediate cause of death	DURATION
Cardio-vascular renal disease	
Due to	
Due to	
Other conditions Fracture, right hip - Diabetes, Accidental fall.	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of September 20, 1945
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) At her home
Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: M. N. Greeley M. D. or other
Address: Elkton, Md. Date signed: Oct 16

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10024

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Cecil

City or town: Perryville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: .....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: .....

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1129 Harford Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3. (a) FULL NAME Joseph Nagle.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Elizabeth K

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 20. 1880

8. AGE: Years	Months	Days	If less than one day
64	10	29	..... hrs. ..... min.

9. Birthplace: Baltimore Co. Md.

(Town, county, and state)

10. Usual occupation: Stone Cutter

11. Industry or business: .....

FATHER 12. Name: Nagle

FATHER 13. Birthplace: Md.

MOTHER 14. Maiden name: Martha Winters

MOTHER 15. Birthplace: Md.

16. Informant: Elizabeth K. Nagle

Address: 1129 Harford Road

17. Burial

(Burial, cremation, or removal. Which?) Date thereof 10/23/45 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Parkville Md.

18. Funeral director: Wilhelm Sons Inc

Address: 1214 E. Fort St.

19. 10/22 1945 [signature] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19 1945 at 1.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary	
Due to: Thrombosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? deputy

23. SIGNATURE: [signature] M. D. or other

Medical Examiner for Cecil County

Address: Perryville Md. Date signed 10/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09994

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Veterans Administration, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years 9 mo. 4 da.

Hospital, institution, or street address where death occurred:
Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Brunswick
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 914 East C. Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I ✓

3. (a) FULL NAME: PIERCE, Joseph D.

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Carrie B. Pierce

7. Birth date of deceased (mo., day, yr.): December 24, 1894 (December 24, 1894)

6.(c) If alive, give age: Unknown years

8. AGE:

Years	Months	Days	If less than one day
50	9	22	- hrs. - min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Brakeman

11. Industry or business: -

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records, Veterans Administration, Perry Point, Md.
Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 10-17-45 (month) (day) (year)

Cemetery or crematory: Park Heights

Location: Brunswick, Md.

18. Funeral director: C.H. Feete & Bros.
Address: 19 W. "B" St., Brunswick, Md.

19. Oct. 17 19 45 (Date rec'd by registrar) Registrar: Irene E. Dunphy

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16 19 45, at 7:10P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12, 19 27, to October 16 19 45

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Tuberculosis, pulmonary, chronic active, far advanced	3 yr. 10 mo.
Due to	
Due to	
Other conditions: Dementia Precox, Hebephrenic	24 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op. -

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?): -

Means of injury: - Injured at work? -

23. SIGNATURE: A.E. KROLINGER, Lt. Col., M.C. Clinic Dir. or other
Address: Veterans Administration, Perry Point, Md. Date signed: 10-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10025

★ Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year.

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 1 hour.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Elkton Rural.

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. 1

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Phoebe J. Pinis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Married

6.(b) Name of husband or wife: George Pinis

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): June 7 1902.

8. AGE: Years	Months	Days	If less than one day
43	3	1	hrs. min.

9. Birthplace: Lake Opinicon, Ontario (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Iden Randall

13. Birthplace: Canada.

MOTHER — 14. Maiden name: Mary Jackson

15. Birthplace: Canada.

16. Informant: George Pinis

Address: Elkton RD Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 3 1945. (month) (day) (year)

Cemetery or crematory: Elkton cemetery

Location: Elkton Md

18. Funeral director: H. W. Pippin

Address: Elkton, Maryland

19. Oct 3 19 45 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1st 19 45, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cirsute	
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner Cecil County

Address: Rising Sun Md. M. D. or other

Date signed 10-2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

10026

Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Union Hospital

How long in hospital or institution? 5 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Capt. Charles Benjiman Schamerhorn

3. (b) Social Security Number: 054-16-0327

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Widowed

6.(b) Name of husband or wife: Helen Schamerhorn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 6, 1883

8. AGE:

Years	Months	Days	If less than one day
62	9	18	..... hrs. ..... min.

9. Birthplace: Athens N.Y. (Town, county, and state)

10. Usual occupation: Capt. in charge Ferry

11. Industry or business: Operations Pub. Chesapeake City

FATHER 12. Name: Henry Schamerhorn

13. Birthplace: N.Y.

MOTHER 14. Maiden name: Elizabeth Pickford

15. Birthplace: N.Y.

16. Informant: Mrs. Elinor Crane

Address: 37 Roanoke Ave, Freeport, L.I.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct 25 (month) (day) (year)

Cemetery or crematory: Jefferson Royal

Location: Peekskill N.Y.

18. Funeral director: H.W. Lippincott

Address: Elkton, Md.

19. Oct 25 1945 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 25 - 1945 at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. - 1 - 1945 to Oct 25 1945

and that I last saw h... alive on Oct 25 - 1945

Immediate cause of death	DURATION
Acute Cardiac Dilatation	
Due to: Chronic myocarditis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underlioe the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Jas. J. Cassavale M. D. or other

Address: Elkton Md. Date signed Oct 26 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-a)

10027

CERTIFICATE OF DEATH

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: CECIL

City or town: VETERANS ADMINISTRATION, Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:
VETERANS ADMINISTRATION, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penna. County: Philadelphia

City or town: Philadelphia, Pa.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1725 Juniata Street
(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. II

3.(a) FULL NAME: SMALARZ, Stanley T.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): November 18, 1911

8. AGE:

Years	Months	Days	If less than one day
33	11	9	– hrs. – min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: –

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Veterans Administration, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 10-27-1945 (month) (day) (year)

Cemetery or crematory: Holy Sepulchre

Location: Philadelphia, Pa.

18. Funeral director: Edward H. Szweda Edward Szweda

Address: 1701 W. Hunting Park Ave.

19. 10-27-45 (Date rec'd by registrar) 19 45 Irma E. Daughety Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 19 45, at 2:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18 19 45, to October 27 19 45 and that I last saw him alive on October 26 19 45

Immediate cause of death	DURATION
Strangulation by hanging	
Due to	
Due to	
Other conditions: Psychosis unclassified Over 5 mo.	

(Include pregnancy within 3 months of death)

Major findings of operation: –

Date of op.: –

Autopsy results: Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: 10-27-45

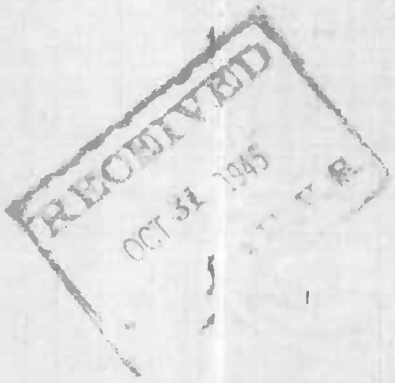
Where did injury occur? Veterans Administration, Perry Point, (City or town) Md., Cecil (County) Md. (State)

Injured at home, farm, Industry, public place (where?): –

Means of injury: – Injured at work? –

23. SIGNATURE: R. C. Dodson M.D. Medical Examiner Cecil County
R. C. DODSON, Coroner M. D. or other

Address: M.D. Rising Sun, Md. Date signed: 10-27-45


RECEIVED
OCT 31 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-1)

10028

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death: 83 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Perryville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Emma Morgan Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Samuel T. Smith
6.(c) If alive, give age: 88 years

7. Birth date of deceased (mo., day, yr.): Aug. 4, 1862

8. AGE: Years 83 | Months 2 | Days 5 | If less than one day ... hrs. ... min.

9. Birthplace: Perryville, Cecil Co. Md.
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER
12. Name: Thomas Morgan
13. Birthplace: Cecil Co. Md.

MOTHER
14. Maiden name: Virginia Boyd
15. Birthplace: Md.

16. Informant: Samuel T. Smith
Address: Perryville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 13, 1945 (month) (day) (year)
Cemetery or crematory: Asbury
Location: Perryville, Md. (Rural)

18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. Oct. 13 1945 Irma E. Vaughn
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 9th 1945 at 10.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1943 to Oct. 9 1945
and that I last saw h... alive on October 9 1945

Immediate cause of death: Chronic valvular Heart Disease — DURATION: 5 yrs

Due to:

Due to:

Other conditions: General Arteriosclerosis — 6 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other
Address: Perryville Md. Date signed: Oct. 10, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for the change of age as shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22a)

10029

CERTIFICATE OF DEATH

State File No. G98 OCT 17 1945

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: VETERANS ADMINISTRATION (If outside city or town limits, write RURAL and give nearest town)

PERRY POINT, MD.

How long in above place of death? 11 mo. 27 da.

Hospital, Institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: -

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1045 Harford Avenue, Baltimore, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I ✓

3. (a) FULL NAME: STATEN, Eugene

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Thelma ? Staten

6.(c) If alive, give age: Unkn own years

7. Birth date of deceased (mo., day, yr.): September 14, 1892

8. AGE: Years	Months	Days	If less than one day
53 - 52	-	23	- hrs. - min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

18. Informant: [redacted] Address: Hospital Records Baltimore, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 10-9-45 (month) (day) (year)

Cemetery or crematory: Baltimore Natl. Cemetery

Location: Baltimore, Maryland.

18. Funeral director: Pennington & Son

Address: Pennington & Son Havre de Grace, Md.

19. Oct 9 1945 (Date rec'd by registrar) Irma E. Daugherty Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7 1945, at 4:10 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10 1944, to October 7 1945 and that I last saw him alive on October 7 1945

Immediate cause of death	DURATION
General Milliary Tuberculosis	Undetermined
Abscess psoas	Over 1 yr.
Due to:	
XXXXX Other conditions	
Due to: Arteriosclerosis, general, Mild	Over 1 yr.
Other conditions: Psychosis intoxication due to alcohol, chronic paranoid type	Over 1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: -

Date of op. -

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: - Date of -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE: A.E. Trollinger

A.E. TROLLINGER, Lt. Col., M.C., Official M. D.

Address: Director, Veterans Administration, Perry Point Md. Date signed: 10-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 10039 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mos
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Elkton R.D. 3
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Samuel S. Garrington

3.(b) Social Security Number: 222-03-8538

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	

6.(b) Name of husband or wife: Edna Garrington
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 3 - 1890

8. AGE: Years 55 | Months 1 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual occupation: Brick Layer

11. Industry or business

FATHER 12. Name: Elsie Garrington
FATHER 13. Birthplace: Balto. Md

MOTHER 14. Maiden name: Mary Moore
MOTHER 15. Birthplace: Balto. Md

18. Informant: Edna Garrington
Address: Elkton Md R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 16-1945 (month) (day) (year)
Cemetery or crematory: Center Meeting
Location: Kennet Square Pa

18. Funeral director: P. F. Fraser
Address: Newark Del

19. Oct 16 1945 (Date rec'd by registrar) F R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 15 1945 at 7:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1945, to Oct 15 1945
and that I last saw him alive on Oct 14 1945

	DURATION
Immediate cause of death: Acute Coronary Thrombosis	5 minutes
Due to: Coronary Sclerosis	2 yrs
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E Hughes Hunter M. D. or other
Address: Newark, Del Date signed 10-15-45